Introduction

Thinking about Eating Disorders through Anthropology, and the Other Way Around

It is an unexpectedly chilly morning in early June 2019. I am walking to the residential facility for eating disorders called Il Giardino[1] (literally The Garden) as I have been doing almost every day for nearly a year now. One can glimpse the distinctively orange walls of the sixteenth-century villa hosting the facility from above and below, whether one is ascending or descending from the small grey-coloured town in central Italy where it is located. The five-minute walk from my flat is usually very quiet, but today I find cars stuck in line one after the other. As soon as I turn the last corner, I see a red car blocking the way in front of the entrance to the building, with two people standing just outside, talking to someone in the car. While getting close to the red car I bump into the nutritionist Irma, who greets me with 'Oh thank God you are here Giulietta, today we really need help. It's one of those days that you want to forget. Look at what I have to do'. Irma then moves closer to the car and starts talking to someone inside. I can see now that it is a young girl, eleven or maybe ten years old. She is holding tight to the car seat. I infer that the two adults standing near Irma are the girl's parents. 'Come on Carlotta, let's go up. The drawing group is starting in a bit, it will be fun!', Irma tries to convince her. But Carlotta keeps shaking her head. At that point, the girl's father enters the car to pull his daughter out. Carlotta starts screaming that she does not want to go, while her father releases her from the rope attached to her seatbelt, which had reportedly been necessary to prevent her from trying to jump out of the car during the trip. Carlotta's father pulls her out by force and then drags her into the building with Irma's help. Carlotta's mother follows them tearfully, and keeps repeating: 'If mummy and daddy leave you here, it's only to help you; we can't help you at home'. They all disappear behind the orange walls, as I step up across the street to follow them inside, briefly encountering the startled look of a passer-by.

Just what goes on inside this building is, in fact, not obvious. Observing it while descending from the town centre, which is perched on a hill, one might guess that there is a large garden within its walls, as centuries-old trees reach over the top. Sometimes, especially in spring and summer, one can hear distant voices of girls coming from within. At times they are chatting, at times crying, at times laughing, and at times – it seems – acting. What happens here is closely connected to a much more recognisable and prosaic space, just a ten-minute walk from the orange villa as you continue to descend towards the ancient city walls: the local health centre (*centro salute*). Only by reading the small plaque placed on the front door of the villa can one make the connection: 'Residential Facility for Eating Disorders Il Giardino' is written under the name of the respective local health unit[2] and the name of a local charity fund. Similarly, if one goes to the health centre further down the road, one can read that the third floor hosts the 'Eating Disorder Day Service Il Giardino', provided by the same local health unit. Seemingly different spaces are thus brought together for apparently the same 'thing' – that is, 'eating disorders'.

Classified as 'mental illnesses' in the *Diagnostic and Statistical Manual of Mental Disorders*[3] (*DSM-5*) of the American Psychiatric Association (2013), what are now known as 'eating disorders' are a growing concern globally. First appeared in the clinical literature as 'eating disorders' in 1981 with the creation of the *International Journal of Eating Disorders* (Yates 1989: 814), eating disorders have been defined as 'a social epidemic' linked to 'Westernisation' (Gordon 2000): every year in the world millions of people are reported to fall ill, and international research suggests that the numbers keep growing (Miskovic-Wheatley et al. 2023; Schmidt et al. 2016; The Lancet Diabetes and Endocrinology 2023). Among eating disorders, 'anorexia nervosa' and 'bulimia nervosa' are defined in the *DSM-5* as 'a persistent disturbance of eating-related behaviour' due to body weight and shape becoming an 'obsessive preoccupation'. They are described as being characterised by 'insufficient or excessive food intake', often accompanied by 'self-induced vomiting, purging and compulsive exercise' (American Psychiatric Association 2013). With a mortality rate between 4% and 5%, anorexia nervosa, together with bulimia nervosa and substance use disorders (in particular opioid use), is reported to have the highest mortality rate of all mental health conditions, figuring among the most common causes of death for young Europeans and North Americans after road accidents (Arcelus et al. 2011; Auger et al. 2021; Chesney, Goodwin and Fazel 2014; Smink, van Hoeken and Hoek 2012). This is linked, the scientific literature reports, to the high rates of relapse after treatment (Khalsa et al. 2017). Although a fixed definition of 'recovery' is problematised both by those living with eating disorders and by scholars (Eli 2016; LaMarre and Rice 2021), according to clinical definitions fewer than half of patients with anorexia or bulimia nervosa fully recover in the long term

(Miskovic-Wheatley et al. 2023; Schmidt et al. 2016) and between 10% and 23% of cases develop into 'chronic conditions' (Berkman, Lohr and Bulik 2007; Fichter et al. 2017; Quadflieg and Fichter 2019).

Most people in Europe, North America and Australia today are familiar, even if to different extents, with eating disorders. This is likely the result of, on the one hand, the efforts of healthcare professionals, associations of parents and sufferers themselves to bring more attention to the issue, and, on the other, of an increased media attention due to the apparently 'exploding' numbers of new cases in recent years, especially since the beginning of the Covid-19 pandemic and the impact of lockdowns and social distancing measures on mental health (see Devoe et al. 2023; Linardon et al. 2022; Schneider et al. 2023). We now find eating disorders featuring not only in memoirs, novels and graphic novels,[4] but also in recurrent articles on national newspapers,[5] and in movies,[6] TV series[7] and documentaries[8] on popular TV channels. All of this means that, today, most people in these parts of the world know that those with an 'eating disorder' have some kind of issues with food that make their eating behaviour strange, often leading to severe weight loss, and that treatment involves some kind of psychological therapy and monitored eating to bring back 'normal eating' and 'normal weight'. But if we go back to Carlotta and start looking at what happens behind the orange walls of Il Giardino, we see that things are much more complicated than that.

By the time Carlotta's parents manage to leave, it is lunchtime. Carlotta refuses to eat, and when she is told that she must eat at least part of the meal before she can leave the dining room, she says an unconvinced 'OK'. Then she sneakily hides some of the food in her tissue and some under the plate, and throws some more on the floor. Observing her from the back of the room, standing next to me, Irma looks worried: 'Most patients do this at the beginning, but it's striking that she does it at such a young age. She already knows all the tricks!' Indeed, one of the key skills that I had to learn for my role as volunteer – one that all interns and professionals working here must learn – was 'training my eye' to spot patients' tricks to hide food during mealtimes: 'It is stronger than themselves at this stage, they can't help it. That's why we have to control them from above, like vultures', Irma continues. Three more 'vultures' are walking around the tables in the dining room, stopping when they notice something that should not happen: too much tomato sauce or oil on a napkin, too many breadcrumbs on the tablecloth, too much fruit cut away while peeling it … the list could go on. Patients' aims are apparently always the same – newcomers are taught by Irma and by her colleagues: 'Reducing the number of calories[9] ingested, to reduce weight gain'.

What is here classified as an 'eating disorder' may seem, to an external and untrained observer, to have to do with food, calories and weight. As we will see in this book, however, both the patients and the professionals, although in different ways, seem to agree on one aspect: 'It's not just about food'. If eating disorders are not just about food, then, what are they about? In this book I attempt to provide an ethnographic answer to this question. The answer, we will see, depends on who gives it: patients, their family carers and professionals have different ideas about and theories of what an 'eating disorder' is, and even within these groups different understandings circulate of what is going on. These differences, and the complex effects produced by their circulation and encounter, are at the core of the difficulty of caring for people with eating disorders.

What This Book Is, and What It Is Not

This book is an in-depth ethnographic account of an Italian public treatment centre for people diagnosed with an eating disorder. Based on eighteen months of fieldwork that took place between July 2018 and August 2019, and then from October 2022 to February 2023, the book sits at the intersection between anthropologies of science and biomedicine and anthropologies of ethics, care and kinship, as it examines the practices and the ethics of care that emerge when patients, their families and healthcare professionals meet and clash with one another inside and outside the spaces of treatment. The book, however, is not primarily about whether these care practices 'work' or 'fail'. On the contrary, it situates itself among studies of the failures of eating disorder treatment in other countries by making a case for thinking beyond a binary conception of success or failure. This is because, we will see, even continuous attempts on the part of well-intentioned therapists to do the right thing sometimes are not enough and lead to death, as things turn out to be always more complex. The aim, instead, is to learn, through an analysis of the kind of care that one can find in these spaces, something new about eating disorders and something new about people, which has relevance for eating disorder treatment because it can show where attention and action should be directed for things to get better.

We will see that the kind of care found in the clinic calls for rethinking existing understandings of the relationship between food and kinship. Contributing to both the more specialised literature on eating disorder treatment and to the wider anthropological literature on food and kinship, the central theoretical argument of this book is that it is not only that food is a 'substance of relatedness' which generates kinship (Carsten 1995), but the reverse is also true. What I mean by that is that food can function as a vehicle to make or unmake kinship (by refusing it), and, in turn, kinship itself can become a kind of 'substance' – a medium – that shapes whether and how food is incorporated into persons. This suggests a co-substantiation of food and family, but in a way that differs from existing anthropological accounts. The book thus ultimately argues that it is not only that food makes people into kin but also the other way around – kinship also makes and unmakes people through food, with complicated consequences for both the patients and the work of healthcare professionals. This also seems to suggest that even people in a European country like Italy may not be as 'individual' as one might think. They might be 'dividual' and 'partible' persons, in a way analogous to the Melanesians famously described by the British anthropologist Marilyn Strathern (1988, 2009, 2018): the patients in this treatment centre – their very bodies – we will see are constituted by their social relationships.

The book is relevant for scholars, graduate and undergraduate students from different disciplines. For medical and psychological anthropologists it encourages further thinking about the ethics of care, especially about the complexities of caring for those who need care and yet struggle to see themselves as in need of care. For social anthropologists and other social scientists it enriches the conversation on the relationship between food and kinship, speaking in new ways to classic questions in these fields. For psychologists, psychiatrists and other clinicians it offers a distinctive intervention into debates surrounding eating disorders, being i) the first book-length qualitative study of eating disorder treatment in a European country with a national healthcare system, ii) the first book-length ethnography that brings together the voices of patients, healthcare professionals and families during and *after* treatment (the latter two groups having received considerably less attention compared to the patients) and iii) the first ethnographic book to address the specific difficulties posed by preadolescent patients, a recent and increasingly alarming phenomenon.[10]

Two clarifications are needed here. The first one is that this book does not generalise about eating disorder treatment, nor about eating disorder treatment in Italy. It is a description of the practices and ethics of care in the particular treatment centre where I worked, and yet it highlights issues that are both anthropologically interesting and rich with clinical implications. The book examines care in a treatment centre that mostly admits patients with anorexia and bulimia nervosa. These are typically considered the most severe forms of eating disorders (Gibson, Workman and Mehler 2019; Miskovic-Wheatley et al. 2023) but are not the only ones, and it is being increasingly recognised that other forms, such as 'binge eating disorder', are not less dangerous (American Psychiatry Association 2013). However, the reader will notice that most of the literature that I refer to here is based on research conducted on anorexia nervosa. This is because bulimia nervosa was theorised as a separate illness from anorexia nervosa only in 1979, having existed until then as a 'sub-type' of the latter (Squire 2003: 17). Although it is now clinically recognised that the two conditions share a desire for thinness, body dissatisfaction and fear of weight gain – and that they can often turn into one another during one lifetime (Fairburn, Cooper and Shafran 2003), with between 20% and 61% of people experiencing more than one type of eating disorder (Miskovic-Wheatley et al. 2023) – they are categorised as separate pathologies because their behaviours seem radically opposed: anorexia mostly consists in self-starving, bulimia in binge eating and purging. As pointed out by the feminist psychologist Maree Burns (2004: 269–70), this strict categorisation obscures the relatedness between the two conditions: bingeing is often a consequence of extreme dieting, and many anorexic women practise binge eating and purging.[11] Some (e.g., Squire 2003) have suggested that bulimia is placed lower in the medical hierarchy than anorexia because bulimic practices embody a liminality that disrupts normative values of Western femininity, whereas anorexic practices are read within a continuum of approved feminine behaviour and 'western assumptions about successful selfhood': people with anorexia are supposedly seen by both patients themselves and by professionals as having 'something extra' that distinguishes them from the 'weakness' of those with bulimia (Burns 2004: 276). In this book I do not pay much attention to distinguishing patients according to their specific diagnosis of anorexia or bulimia nervosa, as this was not something that seemed to matter in my field site. Although I occasionally heard comments along those lines, both among professionals and among patients themselves, usually such comments had the aim of criticising simplistic views and did not come to shape differently the issues I examine.

The second necessary clarification is that in this book I will be referring to patients who are 'biologically female' – unless otherwise specified – because virtually all patients in my field site were assigned female at birth. I will not be discussing why eating disorders seem to affect many more girls or women than boys or men, for example. A lot has been written on this already, especially by feminist-cultural scholars in the late 1980s and 1990s (e.g., Bordo 1993; MacSween 1993; Orbach 1986; Weiss 1999). However, it is worth mentioning here that whereas, until recently, it had been taken for granted in the literature that about 90% of eating disorder patients were assigned female at birth, researchers and clinicians have started commenting that these numbers might be incorrect (Halbeisen, Brandt and Paslakis 2022; Raevuori, Keski-Rahkonen and Hoek 2014): many adolescent boys and men seem now to be suffering from what might be called an obsessive relationship with their bodies, physical exercise and food – a relationship that, in addition to manifesting itself in the search for extreme slenderness, may often find expression in the search for an extremely muscled physique, what some call 'bigorexia' (Mosley 2009). It has been suggested that the reason behind such great disparity in numbers is therefore not so much that boys and men 'are not affected', but that i) they are less willing to seek help because of the very idea that eating disorders are 'women's stuff', and ii) eating disorders in boys or men assume not only the forms of anorexia, bulimia or binge eating, but also forms that have not been explored and categorised as illness yet (Dalla Ragione and Giombini 2014: 27–28; Halbeisen, Brandt and Paslakis 2022). Little is known about eating disorders in those who are assigned male at birth, as they have been largely excluded from research despite findings from recent epidemiological studies indicating marked increases in the prevalence of eating disorders among them (Murray et al. 2017). These are all important issues, especially because they result in misrecognition of symptoms, delayed care, increased severity at presentation for treatment and reduced survival compared to women. But they are issues that will not be addressed in this book.

The rest of this introduction turns first to a brief history of the emergence of 'eating disorders' as an object of interest in psychiatry and in the clinical sciences, and subsequently in history and in the social sciences, to show how eating disorders have been puzzling to scholars from very different disciplines. It then focuses on a review of the anthropological literature on eating disorders and eating disorder treatment to show how, in the last three decades, ethnographic studies have called into question much of what has been seen as the 'common sense' regarding these conditions, developing accounts instead of how disordered eating is grounded in social structures and relationships that tend to be obscured in both popular and clinical framings. What eating disorders are, we will see, is a question that sparked long and contested debates within and beyond anthropology, and these debates have direct relevance for treatment. I situate my research within such work and other relevant literature on care, clinical worlds, food and kinship, to outline the key contributions of the book before concluding with an overview of the chapters' content.

From Early Clinical Accounts to Contemporary Treatment Approaches

What is now called 'anorexia nervosa' has been a named clinical entity since the 1870s. Although the British physician Richard Morton is credited as the first to describe a seemingly similar condition as a psychiatric illness in 1694 under the name of 'nervous consumption', it was only in the 1870s that the medical doctors Charles Lasègue (1873) and William Gull (1874) used the modern terminology, in France and England respectively.[12] Following the psychiatric nosology of the time, these clinicians associated anorexia with other 'hysterical affections'[13] and identified its roots in 'suppressed emotional troubles' occurring during maturation (Lasègue 1997 [1873]: 492–93). As the linguistic etymology of anorexia suggests (incorrectly, it would now be held), these scholars saw a 'want of appetite' – not due to any physical disorder, they thought, but to 'a morbid mental state' (ibid.) – to be the crux of the condition. This assumed 'want of appetite' was also observed to be accompanied, notwithstanding the emaciation that resulted, by a 'peculiar restlessness' and hyperactivity (Gull 1997 [1874]: 499–500; Lasègue 1997 [1873]: 494).

From the end of the nineteenth century, the French father of modern neurology, Jean-Martin Charcot, and then his student Pierre Janet became pioneers of what would later be called the 'psychosomatic' view of anorexia nervosa. Both physicians agreed, even if with different theories of the pathogenic mechanisms and therefore of the necessary treatment, that anorexia had something to do with the relationship between mind ('psyche') and body ('soma'). Charcot (1889) gave more prominence to the neurological pathways through which this 'hysterical' condition manifested, taking the body as his primary focus, whereas Janet (1907) gave a more prominent role to the psyche, focusing on processes of what he called 'dissociation' and on the psychosomatic expressions of the traumatic events of one's past that were supposedly stored in what he called the 'subconscious' (Lester 2019: 38–39).

When the Austrian neurologist Sigmund Freud began to study anorexia nervosa in the early twentieth century, the relationship between mind and body became the focus of a new intellectual and therapeutic movement called 'psychoanalysis', as he offered an understanding of anorexia – which was still categorised as a form of hysteria – that combined Charcot's attention to physiology with Janet's on the subconscious. Freud's (1918) explanation of anorexia nervosa, and the post-Freudian developments that followed, provided the basis for most current approaches to eating disorder treatment, as they brought the questions posed by Charcot and Janet into the domains of sexuality and gender: anorexia became, in Freud's framing, mostly an issue of incomplete or improper sexual and gender development, which for him were one and the same. Subsequent psychoanalytic thinkers especially framed food refusal as a rejection of adult sexuality and as an attempt to return to a state of childhood and avoid the responsibilities that come with being an adult woman; so-called 'psychodynamic' approaches focused on the importance of psychotherapy as a way to bring out the 'inner' workings of the mind and study the dynamic relations between the patient's behaviour and its 'unconscious motivations' (see Lester 2019: 40–42).

In the second half of the same century, the German-American doctor and psychoanalyst Hilde Bruch (1962: 188) published an article in *Psychosomatic Medicine* based on her treatment of twelve young patients with anorexia nervosa, describing their condition as being characterised by 'three areas of functionally disordered psychological experience': i) 'a disturbance in body image of delusional proportions' – hence the fear of becoming fat; ii) 'disturbance in the accuracy of perception or cognitive interpretation of stimuli arising in the body', such as hunger, fatigue and weakness; and iii) a 'paralyzing sense of ineffectiveness' (ibid.: 188–91). However, it was Bruch's monograph *The Golden Cage* (1978) that, drawing on conversations with her patients and influenced by social changes later classified as feminist, brought anorexia into broader public consciousness. Here she argued that for young women pressured to satisfy social expectations anorexia was a means of asserting control and power through an extreme practice. At about the same time, the British psychiatrist Arthur Crisp (1980) similarly framed anorexia as an 'adaptive disorder', whereby the prepubertal body size achieved through starvation allowed women to avoid an adult social and sexual life.

As a doctor, Bruch had also noted how starvation likely played a role in influencing 'thinking, feeling and behavior' (Bruch 1978: 4), turning 'formerly sweet, obedient and considerate' girls into 'demanding, obstinate, irritable and arrogant' ones (ibid.: 2) who, 'like other starving people', were now 'eternally preoccupied with food and eating' (ibid.: 8). In recognition of these effects of starvation, Bruch emphasised the importance of 'weight correction' in the first phase of treatment, since one could not expect to do 'meaningful therapeutic work with a patient who is starving' (1978: 129). However, she also remarked that weight correction must occur 'as part of an integrated approach' (ibid.: 98) which might include 'family disengagement' (ibid.: 112) and 'changing the [patient's] mind' (ibid.: 128). She thus warned against treatment that relied simply on 'behavioral modification' to achieve weight gain, as that would generate a 'battle of wills' (ibid.: 99). Individual psychotherapy was her preferred treatment method, through which she aimed to help patients develop a 'capacity for self-directed actions' (ibid.: 130).

In the same year that Bruch's masterpiece was published, two other works later considered 'groundbreaking' in the field of eating disorders came out: Salvador Minuchin, an Argentinian physician who trained in child psychiatry and psychoanalysis in New York, published with his colleagues at the University of Pennsylvania a book titled *Psychosomatic Families: Anorexia Nervosa in Context* (Minuchin, Rosman and Baker 1978). This book placed anorexia, as well as its cure, in the family system: it argued that since anorexia developed within a family context characterised by certain 'dysfunctions', rather than separating the child from their parents – as Bruch seemed to suggest – treatment had to be directed at families to address these problematic aspects. At about the same time, in Italy the psychiatrist Mara Selvini Palazzoli (1978) also called for shifting from 'individual therapy' to 'family therapy' in the treatment of anorexia. These theories informed research work undertaken at the Maudsley Hospital in London during the 1980s, laying the foundation of what became 'family-based treatment' for eating disorders (Russell et al. 1987). As we will see through the chapters, this is now mostly focused on engaging the family as a 'resource' for recovery, through 'empowering' the patient's parents to have an active role in treatment. In the meantime, in the UK the psychiatrist Gerald Russell (1979) first distinguished bulimia nervosa as 'an ominous variant' of anorexia characterised by overwhelming 'urges to overeat' that lead to binges and purging measures. Accordingly, the publication in 1980 of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*), in which a section on 'eating disorders' appeared for the first time,[14] included a separate diagnostic category 'bulimia nervosa'.

In this period, 'cognitive' theories that linked thought patterns learned in specific environments to specific behaviours bypassing the 'unconscious' brought a new model of human behaviour and a new understanding of anorexia nervosa, whereby people would receive positive reinforcement for losing weight up to the point that the patient's self-destructive practices became 'habituated' and very difficult to discard, unless their 'faulty cognition' and 'distorted thinking' were addressed (see Lester 2019: 45). In this context, cognitive behavioural therapy (CBT) started to be a common favoured approach, also because it generated visible and quantifiable improvements (even if only in the short term, many argued) that responded well to the changes in most healthcare systems towards concerns with treatment ‘evidence’ and ‘cost-effectiveness’ (ibid.: 46). During this turn towards increasing attention to categorisation and quantification, in the 1980s and 1990s several eating disorder ‘diagnostic scales’ were also developed. Among these were the Eating Disorder Inventory and the Eating Disorder Examination Questionnaire, the sub-scales of which aimed to quantify issues such as ‘drive for thinness’ and ‘body dissatisfaction’ (Marks 2019: 1384).

It is interesting and important to highlight that these various theories and approaches to eating disorders are not mutually exclusive, and most treatment centres in Italy and elsewhere – even most clinicians – combine them in their work, including staff at Il Giardino. We will see that the different ways of conceiving the relationship between body and mind, and the ways in which the ‘biological’, the ‘psychological’ and the ‘social’ dimensions of eating disorders are thought to interact and affect the patient, in treatment turn into practical questions that sometimes demand competing answers.

The Social in the Picture: From ‘Culture-Bound Syndromes’ to ‘Embodied Processes’

From the 1980s, historians and social scientists in the United States and Europe took an interest in the history of anorexia. They traced its origin back to late nineteenth-century Victorian bourgeois families, but they also associated it with self-starvation among medieval Catholic women (see Brumberg 1988; Vandereycken and van Deth 1994). Specifically, the American historian Rudolph Bell (1985) argued that thirteenth- to sixteenth-century Italian ascetics manifested in their ‘holy anorexia’ dynamics that also characterise contemporary anorexia, and that both conditions reflect a struggle for female autonomy within patriarchal social structures. Bell’s colleague Caroline Bynum (1987) argued against reducing the food abstinence of ascetics in the Middle Ages to ‘eating disorders’, observing that food was the only thing medieval ascetics could control about themselves and their surrounding world. Renouncing food, Bynum argued, allowed women to exercise ‘self-determination’ – leaving the family, avoiding marriage duties and reaching redemptive leadership roles within the Church.

At the same time, with the rise of feminist psychology, political analyses of this ‘feminine pathology’ (Orbach 1986) started proliferating. The feminist sociologist Morag MacSween (1993) suggested that anorexic *practices*, rather than women’s vulnerabilities, should have been the focus of enquiry. Accordingly, the feminist philosophers Susan Bordo (1993) and Gail Weiss (1999) analysed anorexia as an extreme practice embodying the social denigration of the body and the feminine. Through these literatures, ‘anorexia nervosa’ emerged as a condition with a multidimensional causation, a seemingly rich history and a peculiar epidemiology. A ‘biocultural disorder’ for some (Eli and Ulijaszek 2023), it became interesting to anthropologists.

When anthropological work on anorexia was first published in the 1980s, models of ‘culture-bound syndromes’ were the focus of medical anthropology and transcultural psychiatry. Since these syndromes seemed to be unique to populations in the ‘developing world’, anorexia was an attractive example because it was felt, at the time, to be one syndrome exclusive to ‘the West’ (Di Nicola 1990; Prince 1985; Swartz 1985). In the 1990s, the culture-boundedness of anorexia was problematised by calling attention to the religious ascetic dimension that informs self-starvation (Banks 1992) and to the cultural ‘ordering’ of the disorder performed by Euro-American psychiatry (Gremillion 1992). ‘Non-fat-phobic anorexia’ was introduced to refer to forms of anorexia now being ‘found’ in China and Hong Kong (Lee 1996; Lee, Ho and Tsu 1993). Further anthropological work challenged the exclusive association of anorexia to ‘Western cultural concerns’ with body fat or weight (Littlewood 1995; Ritenbaugh et al. 1996), laying the foundation for analyses of eating disorders in the Eastern hemisphere and the Global South. These were brought together in a *Culture, Medicine and Psychiatry* special issue on ‘New Global Perspectives on Eating Disorders’ (Becker 2004a), offering a compelling argument against the framing of eating disorders as ‘disorders of the West’ simply transportable to other contexts via ‘Westernisation’ (e.g., Becker 2004b).

In recent decades, in fact, shifts of theory and interest in medical anthropology – from culture-bound syndromes and explanatory models of illness to globalisation and ethnographies of ‘the body’ and ‘self’, for instance – aligned anthropological studies of anorexia with critical analyses of experience and practice. Anthropological work on eating disorders largely shifted to analyses of the micro-scale of lived experience in European and American contexts, calling attention to the ‘cultural logics’ (Eli and Warin 2018) that drive eating disordered practices and showing how these practices are embedded within normative social environments. It has been noted that this more recent ethnographic work has analysed anorexia as an embodied process, rather than as a disordered state (Eli and Lavis 2022; Eli and Ulijaszek 2023; Eli and Warin 2018).

In imposing a Cartesian mind–body split, medicalisation had tended to make anorexia a mental disorder – the mind’s war on the body – requiring psychological conjectures. But by erasing the Cartesian division and by looking at people with anorexia in their context – a context in which bodies have increasingly become moral arenas wherein eating and exercise test one’s strength of character (Niola 2015; O’ Connor and Van Esterik 2008: 7–8) – people with anorexia emerged as ‘misguided moralists, not cognitive cripples’, and their seemingly extraordinary asceticism appeared then to have very ordinary roots in local values and practices (O’Connor and Van Esterik 2008: 7).

The question then became: how exactly do those who suffer from anorexia become 'misguided moralists'? British anthropologist Sue Benson (1997) characterised eating disorders as 'epidemics of the will', as extreme enactments of Euro-American fantasies of self-control. In this framework, the body is experienced as a project of the self: sufferers try to rewrite their self by changing their body through a paradoxical mixture of voluntarism and compulsion. Extreme food restriction, Benson notes, offers the promise of becoming a master of one's body by winning over hunger, but it ends up undermining 'the very autonomy it seeks to establish' (ibid.: 136).

American anthropologist Rebecca Lester (1997) also tried to address this question in her earlier work. She argued that feminist framings of anorexia as 'the crystallization of culture' (Bordo 1993) – as an extreme embodiment of 'Western' ideals about women's bodies and roles – depicted it as an unconscious, self-destructive social protest. Women were conceived as passive bodies and their 'self' was left unexamined, preventing the understanding of its embodied articulation (Lester 1997: 479–81). Drawing on fieldwork in an eating disorder clinic in the United States, Lester proposed to analyse anorexia through Foucault's (1986) notion of 'technologies of the self' – as a deliberate shaping of the self achieved through culturally meaningful bodily practices. She suggested that the body is seen as the material vehicle of the 'internal self'. Restriction of food, invested with meanings about dependency and nurturance, is therefore used to reconstruct the boundaries of the 'body-self', communicating autonomy (Lester 1997: 485–86). As a response to an extreme awareness that our bodies define us, shaping a chosen body becomes the goal. It is essential, Lester thus argued, to first consider the theoretical project of anorexia – 'the self which is being pursued' – and then examine 'its practice' – the behaviours that bring about the self-transformation (ibid.). A slender body is thus the first visible aim because, in what Lester calls 'the West', it reflects a self that can 'rise above' the need to eat – a morally superior self (ibid.).

Carrying on from Lester's approach, Sigal Gooldin (2008), in her ethnographic study of an outpatient eating disorder unit in Israel, suggested that people with anorexia construct their selves as moral selves through the experience of enduring and overcoming hunger, seen as 'an out of the ordinary accomplishment'. Hunger, which involves physical pain and suffering, is experienced by patients as an enjoyable 'hyper' feeling of power and self-efficiency, becoming a 'selfing device' to make themselves 'moral agents', since self-inflicted hunger is experienced 'as a heroic way of being in the world' (ibid.: 290). Going even deeper than Lester into the specific element of the 'technology of the self' that creates such selves, Gooldin suggests that being anorexic is about being hungry and giving meaning to it, no less than it is about 'shaping the body' (ibid.). Her account constructs anorexia in terms of transforming one's self through an existence that may be numbed through active detachment from one's bodily sensations. But, by being active, this existence is also 'fiercely sensed' (Eli 2012: 2).

Lester's and Gooldin's framing of anorexia as an experiment with the self could itself be said to be culturally specific. Anthropologist Anne Becker (1995) has pointed out how the interest in reflexively cultivating one's body depends on the cultural validation of personal agency with respect to the body, which is in turn linked to the experience of self vis-à-vis the community; it presupposes that the body represents a personal resource for expression (ibid.: 37). In her ethnography of bodily aesthetics in Fiji, Becker outlines a relationship between self, body and society which highlights aspects of self and body boundaries, agency and identity that situate both Lester's and Gooldin's accounts. In Fiji, Becker shows, the cultivation of bodily space is a collective rather than a personal enterprise: bodies and the crafting of their form are the responsibility of the community that cares for them (Becker 1995: 5). Therefore, what bodily form communicates is how one has been nurtured or neglected in his or her social universe, not the attitude of one's personal self. One's body in Fiji also encodes one's capacity and propensity to serve one's social universe in return: in an interesting inversion, too-slim bodies are associated with laziness and inability to work, whereas bigger bodies are associated with productivity and willingness to contribute to the community (ibid.: 56–58). The cultivation of the self through personal manipulation of the body therefore emerges as a concept made possible by 'Western' values that encourage autonomy, independence and competitive work to raise oneself above other selves (ibid.: 127–29).

Nevertheless, Lester's and Gooldin's accounts have important implications for clinical practice in offering new explanations as to why patients can be so resistant to treatment. If the eating disorder is experienced by patients as in some sense an ethical project of self-cultivation, treatment will easily be perceived as an external, intrusive attempt to make their personal projects fail. Their work strongly suggests that if eating disorders are addressed as stemming from 'pathological selves', rather than taken seriously as the very practices by which sufferers *form* their 'self' (Tait 1993: 205), biomedical care will continue to fail. The question thus remains of how to approach these issues in a way that takes people's self-projects seriously, without this appearing to result in a neglect of the severe consequences that the same projects can bring.

Ethnographic Studies of Eating Disorder Treatment

We have seen that there has been an extensive anthropological literature on the possible 'causes' and 'nature' of eating disorders. Less attention has been given to treatment – a perfect place for analysing the 'selves' of daily practice. In line with recent ethnographies that have framed eating disorders as 'technologies of the self' (Eli 2018; Gooldin 2008; Lester 1997), several ethnographic works on treatment have focused on patients' perspectives: on their ambivalence towards treatment as a key element of their 'anorexic being-in-the-world' (Warin 2010), including, most recently, on how the materialities of treatment shape patients' ambivalence about illness and their 'resistance' to recovery (Eli and Lavis 2022).

Lester (2014), for instance, highlighted how patients undergoing treatment in the United States restrict their intake of medication – psychotropic drugs that tackle related symptoms such as depression and anxiety, but also vitamins and mineral supplements – in the same way that they restrict food. Drawing on her earlier work (see Lester 1997), she suggested that medication refusal is for these patients a means of 'self-communication' within a larger ethical project. Taking medications presumes someone who strives towards health, but for these patients the optimal state seems to be deprivation (Lester 2014: 249). Lester's study helps clarify why the common practice of presenting food to patients as 'medicine', on the assumption that they will feel less 'guilty' about eating, often does not work: taking medicines is experienced by patients as a way of taking care of one's body; this goes against their self-cultivation project based on overcoming bodily needs (ibid.: 243–49).

Karin Eli (2014), Anna Lavis (2015, 2016) and Connie Musolino and colleagues (2015, 2016) subsequently reinforced Lester's findings with similar ethnographic studies conducted in Israel, England and Australia respectively. Patients, even those who recognise its dangers and negative sides, experience restricting food as a form of caring for themselves, as their only way out of suffering, providing them 'safety'. This is why, even if they feel the eating disorder is harmful, they may want to maintain it (Lavis 2016: 71–72). Looking at these contradictions ultimately means questioning the notion of an individuated, unified self who can give informed consent to treatment (Berliner et al. 2016: 5).

In 2018 a special issue entitled 'Anthropological Perspectives on Eating Disorders: Deciphering Cultural Logics' was published in *Transcultural Psychiatry* (Eli and Warin 2018). This special issue aimed to explore how anthropological approaches to eating disorders had developed in the decade since the 2004 special issue of *Culture, Medicine and Psychiatry* on eating disorders in a global context. The intention was to provide anthropological responses to clinical questions about the low rates of treatment success (Keel and Brown 2010), the high rates of treatment 'dropout' (Fassino et al. 2009) and the modes of managing enduring eating disorders (Touyz and Hay 2015; Treasure, Stein and Maguire 2015). Among the contributions, Musolino, Warin and Gilchrist (2018) have examined ambivalence towards help-seeking in Australia, focusing on narrations of what they call 'triggers', i.e., encounters with food and other social stimuli that prompt women with disordered eating to re-engage in restrictive or binge-purging practices. The authors argue that culturally embedded gendered desires to deny or fulfil certain embodied longings (e.g., for the intensity of the binge or the lightness of the empty body) are fundamental to understanding why people do not seek help or frequently oscillate between recovery and relapse. Lavis' (2018) paper focuses on British inpatients' experiences and examines how patients mobilise practices of eating and not eating to cultivate their relationship with anorexia during treatment. The attractiveness of disordered eating, argues Lavis, lies not in the maintenance of an emaciated body, but in the desire for ongoing illness, with anorexia experienced as a 'safe space' that allows sufferers to 'live through distress' through a 'viscerally felt shield' from the outside world. Similarly Eli (2018), in her analysis of Israeli patients' narratives of their eating experiences, argues that people with eating disorders 'strive for liminality' – actively seeking an ambivalent being through eating disordered practices to survive oppressive familial, institutional and social conditions. Eating disorders, Eli suggests, work as a long-term way of surviving-in-the-world amidst structural vulnerabilities and social suffering.

This body of literature points to the severe limitations of enforced treatment. On the other hand, however, the increasingly celebrated principle of respecting patients' choice seems to be equally detrimental given the intricacies of the conditions in question (cf. Mol 2008). In this context, respecting patients' choice about treatment will not help, as it is likely to lead to chronicisation or death. On this matter, a second strand of ethnographic literature on treatment has usefully drawn attention to how inpatient facilities in the United States (Gremillion 2003; Lester 2007, 2009, 2014, 2018, 2019), Canada, Australia and the UK (Warin 2005) are characterised by settings of care, dynamics of surveillance and treatment practices that unwittingly reproduce the very dynamics that sustain eating disorders, making treatment fail. All these elements – the different authors suggest – are based on a notion of patients' self as lacking in self-discipline, whose problems can be solved by addressing 'the mind'. Still, 'the body' is at the centre of treatment, seen as an uncooperative appendage that needs to be constantly under control.

Helen Gremillion's (2003) ethnography of an eating disorder clinic in the United States contains another interesting and overlooked point. Among other things, she analysed the dynamics between the members of the treatment team – what she calls the 'therapeutic family' (ibid.: 119) – and the patients. 'Affectionate caretaking' was considered a crucial 'natural' feature that professionals had to possess, but at the same time it was perceived as potentially risky, thus requiring staff members to learn to keep a distance through 'minimal mothering' (ibid.: 120). Otherwise, they risked 'overnurturing' patients and generating harmful effects (ibid.: 121–27). Staff members in Gremillion's field site could explain very well how maternal attitudes could lead to over-involvement or punitive behaviours, but less easily what constituted a good nurturing attitude (ibid.: 149–53). A balance between 'involvement' and 'detachment' was seen as necessary, but just where the 'right' balance lay was not clear. Reaching it was known to require time and constant practice. Lavis, Abbots and Attala's (2015) work on the entanglements between eating and caring also invites reflection on this 'slipperiness' of care – on how it is framed both as an innate ability and as something to be learned through training (ibid.: 5–7).

In fact, there has been little attention paid to the professionals in anthropological accounts of eating disorder treatment, other than to point out how well-intended clinicians make sense of their care within systemic failure and end up colluding with the structural limitations of the treatment apparatus within which they work. Lester (2009, 2017, 2018), for example, explored how clinicians strive to provide the best treatment for patients within the constraints of managed care in the United States, which requires quantitively measurable treatment goals. All these works converged into Lester's (2019) monograph – the product of twenty years of ethnographic research in a private eating disorder treatment centre, coupled from a certain point with her own clinical work as a counsellor and informed by her personal struggle with eating disorders from early adolescence into young adulthood. Moving on from her previous framing of eating disorders as 'technologies of the self' (Lester 1997), here she proposes to see eating disorders as ways of extending an ethical demand to others and reframes them as 'technologies of presence' (Lester 2019: 63): as tools that people employ to make themselves seen and responded to in the world. She thus calls for paying attention 'to how professionals care' when facing patients who often do not want to receive treatment, their families in crisis but still resistant to change, and a healthcare system that downplays the kind of clinical expertise that seems to help. She examines how such a situation generates contradictory ideals of recovery and paradoxical notions of the 'healthy subject', thus producing frictions and 'roadblocks' – within a sense of constant precarity due to the system of health insurances requiring quantifiable and predictive evidence of treatment success. Her ethnography is therefore ultimately about how professionals understand practices of care when 'care' and 'harm' are deeply intertwined, and about how they make sense of treatment in the face of such systemic failure – which often leads to more sickness and to death (ibid.: xvii–xviii). She argues that clinicians unwittingly end up assimilating the political-economic logics of US managed care into their understandings of eating disorders, thereby constructing everyday realities of clinical practice that provide ethical space for the withdrawal of care.

This second strand of literature has tended to paint a picture based on a binary conception of success or failure: treatment that should succeed by saving patients' lives and supporting long-lasting recovery clearly fails to do so. This book, instead, takes a step back and examines the difficult care work that is done within the less-than-ideal context of a public treatment centre in Italy, a country with a crumbling but still functioning national healthcare system. This enables the existence of different forms and times of care and makes it possible to see things that are otherwise obscured in managed care contexts, where such care cannot happen in the first place. The book therefore purposefully focuses on the grey areas between 'failure' and 'success' and on how, when difficulties arise and things seem to be failing, professionals – and family carers, too – try other ways to make their interventions work, generating novel forms of care along the way which are not always ‘successful’ but are still worthy of attention and analysis.

Despite a fixation on the family in the history of eating disorder treatment, and despite attention from some ethnographers to how relatedness is ‘reconfigured’ in people with anorexia (Warin 2006, 2010), the role of the family tends to be even more overlooked than professionals in ethnographic accounts of treatment facilities (e.g., Eli and Lavis 2022; Lester 2019; Warin 2005). In these accounts the patient’s family, when present, features mostly as an additional complication (e.g., Lester 2019).[15] In Gremillion’s (2003) notable exception, which examines the production of normalised bodies, subjectivities and families in a hospital-based inpatient programme in the United States, the family features as the realm that offers a template for the anorexigenic power relationships observed within the treatment team and between patients and professionals. Gremillion’s analysis of the treatment team as a ‘substitute family’ focuses on the gendered cultural dynamics that make the mother–child relationship the locus where clinicians locate ‘the heart of the problem’, and that ultimately make treatment fail (ibid.: 104). In this book I go beyond her focus on what does not work in the ‘substitute family’ and show how kinship care in this treatment centre highlights something that is interesting to the anthropology of kinship and of medicine more generally – namely, that kinship relations are seen to need remodelling in order to transform patients’ eating behaviours, and, through those behaviours, their bodies. By examining what food affords to family and what family affords to food, in this book I bring together some of the issues dealt with in the anthropological literature on kinship, and some of the issues dealt with in medical anthropology, to suggest that kinship and feeding are interestingly aligned in both the production *and* treatment of disease.

On Bodies, Care and Ethics

This book is also a contribution to the literature on the ethics of care. It starts by asking how the multiple ‘bodies’ and multiple ‘eating disorders’ of patients and professionals are coordinated during treatment (see Mol 2002): patients and professionals – and within this latter category, different kinds of professionals – each conceive and approach ‘the body’ and ‘the eating disorder’ differently. We will see that, for those who become patients, the eating disorder is a way to better cope with life by reshaping their bodies according to their will and control. For the professionals, the eating disorder is a pathology that has to be treated within the realm of medicine – a deviation from how ‘normal’, ‘healthy’ bodies and minds should ‘function’. But within this second reality, there is more multiplicity. Like ‘atherosclerosis’ in the outpatient clinic studied by Annemarie Mol

(2002) in the Netherlands, the 'eating disorder' as conceived in this treatment centre is not a natural unity. It might form a unity in contrast to the eating disorder experienced by a patient, but we will see that if one looks at the practicalities of treatment, the treatment centre appears to be full of contrasts.

Mol had pointed out that her study provoked the question of how the body multiple and its diseases 'might be done well' – which is, the question of 'the good' (Mol 2002: 165–66) – but that her purpose was not to answer that question. My book, instead, is an attempt to explore how the multiple dis-eases and bodies that circulate within and outside an eating disorder treatment centre are coordinated with the aim of providing 'good care'. I observe the 'goods' that are sought after, the 'bads' that are fought, and how multiple 'goods' are framed as being good due to the specific limits of what carers can do (ibid.: 176–77). In this sense I follow the approach that Jeannette Pols (2015: 82) calls 'empirical ethics', as I examine the different and sometimes conflicting notions of good care within these specific care practices by analysing the 'goods' that carers and patients strive for, the values and norms they implicitly or explicitly shape and the 'bads' they want to avoid. This places ethics *in* the world of those we study, as a part of everyday practices (ibid.; cf. Brodwin 2013).

From Mol's later work on what she calls 'the logic of care' (2008), I take her approach of avoiding the distinction between 'care' – mostly used to refer to activities, such as washing or feeding, that are done to make daily life more bearable – and 'cure', used for interventions that should ideally heal people from a disease. In an eating disorder treatment centre, especially, things that would be framed as 'care' – feeding, listening – are seen to be the very key to the 'cure'. Therefore, I will use the term 'care' to refer to all kinds of practices going on in the treatment centre, although, we will see, there are different forms of care emerging from different situations. Furthermore, as Mol does in her work on diabetes (ibid.: 7), I take the specificities of care for eating disorders as the focus of why it is important to disentangle care from an immediate assumption of 'kindness', and to be open to including in care also practices that might seem to have more to do with 'force' and 'coercion' but that, upon further scrutiny, reveal themselves as requiring a lot of effort from patients.

A particular kind of affection is in fact expected from staff members of eating disorder treatment units, and yet they are required to perform treatment practices that can also seem antithetical to caring. The necessarily 'harsh' aspects of their job are seen to impede 'connecting' with patients, and vice versa (see Gremillion 2003: 144–45). A complicating factor is that the receivers here of the necessary daily activities of intrusion, surveillance and coercion tend to be high achievers, successful academically and professionally, and apparently capable of making competent decisions in all aspects of their life apart from those regarding their own nutritional intake (Giordano 2005: 1; Kendall 2011: 2). This makes the work of care even more difficult. My book thus explores how the patients' will to remain ill is managed by professionals so that they can go beyond the binaries of 'patient choice' versus 'enforced treatment', and 'cure' versus 'treatment failure' (Lavis 2016: 73). Through what tools do professionals insist and *manage* to insist when patients refuse to eat?

Building on Mol, Moser and Pols' (2010) argument that in care practices the knowledges, technologies, bodies, people and daily lives involved need to be continuously 'tinkered with', here I argue that tinkering with *relationships* of care, and especially tinkering with patients' families, is fundamental to be able to tinker with the food that patients eat, with their daily behaviours and, through all of this tinkering, also with their bodies. The book will indeed show that patients' bodies are a 'border territory' in the healthcare encounter (Hahn 1985: 97–98, cited by Mattingly 2010: 12), as they become the receptacle of 'what is at stake' in daily life for all those involved – patients, families and healthcare professionals (cf. Mattingly 2010: 29). We will also see that the common framing of healing as a 'battle'[16] in this context assumes a very specific meaning, in which not only 'mind' and 'body' often play antagonistic roles but the battlefield is mostly located in 'the mind', with 'the body' being seen as the recipient of the battle's collateral effects. In this I follow Maryon McDonald's (2014) call for making 'the body' the object of ethnography rather than the language of analysis: I note 'the bodies that are acquired' (ibid.) by the professionals, which enable them to see scientifically the bodies of the patients; and I look, too, at how patients *acquire* specific bodies through clinical interactions. In sum, I look at their 'mutual articulation' (ibid.: 130).

The book gives particular attention to the temporality of projects of care (cf. Mattingly 2014a: 39–40), and to the fact that care practices are situated in the specific constraints of practical action and therefore have an experimental and risky character (ibid.: 379–84).[17] The chapters trace the professionals' 'ordinary ethics' as they move between what they feel is 'the ought' and what they can do and therefore 'is' (Lambek 2010: 4–6; Laidlaw 2013): how they speak and act with ethical consequences, how they evaluate actions, how they care and how they are aware of when they fail to do so.[18] But the book also includes storytelling about the activities of family carers – how they perform and experience their caring work, their intentions, their concerns. For both the professionals and the family carers, the aim is to understand the occasions when there are perceived tensions with patients and 'within themselves' – 'moments of moral breakdown' (Zigon 2007: 138) – and to point out the different ways in which they try to act for the best.

On Italy, Food and Kinship

Italy's idealised image as a country where people have an almost 'naturally healthy' relationship with food, thanks to the praised 'Mediterranean diet' and to the care that families supposedly put in cooking and eating together, makes it a particularly interesting country for studying eating disorders. In this romanticised context, more than three million people have received an official diagnosis of eating disorder (Cavanna and Nacinovich 2024). Nevertheless, considering the popular view that, among Europeans, Italians give a specifically strong value to both 'food' and 'family' (Counihan 2004) and that Italy is characterised by a greater 'strength' of family ties (Reher 2004) expressed through reciprocity in providing care for the elderly and children, the anthropological literature on eating disorders and on kinship in Italy is surprisingly scarce. The few ethnographic accounts of eating disorders in Italy are in line with the other anthropological literature reviewed above: Ann Cheney (2012, 2013) conducted a study on disordered eating in Calabria, a region in southern Italy, which describes how women transform gendered relations of kinship and power through practices of not eating, and how such practices allow them to craft locally meaningful moral selves because they mirror the self-sacrificial and morally superior motherly figure 'highly venerated in southern Italian society' (Cheney, Sullivan and Grubbs 2018: 445). Similarly Gisella Orsini (2017, 2021, 2023), in her analysis of compliance and resistance to treatment in a residential facility, suggests that people with eating disorders are actively and deliberately engaged in a project of moral self-transformation that is culturally defined, as it reflects the social expectations of women in these patients' social context and the moral values embodied in thinness, namely the control of bodily needs and pleasure. For this reason, she suggests, patients may accept medical care to achieve objectives other than 'healing': by complying with residential treatment, patients diagnosed with bulimia nervosa, for instance, attempt to '(re)become anorexic' or simply escape from their everyday family environment. These works importantly focus on sufferers' narratives, but they say very little about the specific practices and constraints of treatment as experienced by treatment teams or family carers.

This book aims to start filling this gap, and, by doing so, also to enrich the relatively sparse anthropological literature on Italian kinship.[19] Besides a few dated exceptions that offer a close ethnographic look at the daily lives of families in central and southern Italy (Belmonte 1979; Davis 1973; Galt 1991; Goddard 1996; Moss and Thompson 1959; Pitkin 1985), with a couple highlighting how women's daily food provisioning provides them with a sense of power and fosters a self-sacrificial concept of self (Counihan 1988, 2004; Silverman 1975), the literature on Italian kinship tends to be either more historical and sociological than ethnographic (see e.g., Barbagli and Kertzer 1990; Bell 1979; Bernini 2004; Esposito 1989; Saraceno 2004, 2015) or, when ethnographic, to be mostly focused on race, migration and intimate violence (Krause 2001, 2005; Plesset 2006; Yanagisako 2002, 2018), new reproductive technologies and LGBT parenting (Bonaccorso 2009; Grilli 2018; Guerzoni 2020, 2023, 2024), adoption (Di Silvio 2012), or sexuality and queer activism (Heywood 2018). A relevant exception is the historical and ethnographic work conducted by Barbara Vatta (2012) on kinship in the northern Italian region of Friuli-Venezia Giulia. Her work, although it does not address eating disorders, traces changes in family dynamics including those that regard care through food and argues for a conception of family as 'dependence', showing how 'dependence makes family'.

By expanding on the few works that looked at the interplay between kinship and mental health conditions in Italy (e.g., Giordano 2011, 2018) and at the forms that 'relational labour' takes in the country (Leira and Saraceno 2006; Molé 2008, 2012; Muehlebach 2011, 2012, 2013), my aim is to offer an equivalent, for the anthropology of kinship and medicine, of what Paolo Heywood's (2024) edited collection *New Anthropologies of Italy* has offered for the anthropology of politics, heritage and language. I also want to offer evidence against 'the false assumption that Italian anthropology has nothing to offer to global theory and method' (Herzfeld 2024: 379). Being Italian and having access to the Italian anthropology which has been exclusively published in Italian, but having been trained in the UK and Canada, I second Bonaccorso's (2009: 10) intention to show i) in what ways Italy is a different place from the one depicted by many Anglo-American anthropologists in their earlier as well as in more contemporary studies, and ii) what contemporary 'native anthropologists' trained in the Anglo-American tradition can add when approaching classic questions such as those that have to do with bodies, food and kinship.

Through filling a regional gap, in fact this book also contributes to the wider anthropological literature on the relationship between food and kinship, adding a broader comparative approach to existing ethnographies of eating disorder treatment. After what was seen as a 'crisis of kinship' in the 1970–80s, a new generation of anthropologists suggested that in many sociocultural settings ties of what was now called 'relatedness' were constituted by giving, receiving and sharing food (e.g., Carsten 1995, 1997; Janowski and Kerlogue 2007). Janet Carsten (1995: 223), for example, has famously shown how, among the Malays on the island of Langkawi, feeding (in the sense of both receiving and giving food) is a vital element in the process of becoming a person and participating fully in social relations as kin. In her context, the core substance of kinship is seen to be blood, and the major contribution to blood is seen to be food. Food therefore creates both persons in a physical sense and the substance through which they are related to one another (ibid.: 224). This suggested a processual view of kinship and challenged anthropological definitions that had assumed a universal division between the 'biological' and the 'social', or 'nature' and 'culture'. Similarly, Amazonian ethnographers have shown how commensality is a central means through which indigenous people engage in processes of 'familiarisation' (Fausto and Costa 2013): by eating together and sharing food, people turn into kin (Vilaça 2002) and create intimate relationships.

These authors did not, however, consider much how parental feeding practices intersect with local ideas of what might be called 'good parenting' and 'healthy development'. In her Langkawi work on food as a substance of relatedness, Carsten (1995: 234) mentions that the mother's milk is the source both of shared substance and of 'the strong emotional bond between mother and child', acting as 'the enabling substance of kinship'. She also shows how eating meals in other houses implies a dispersal of 'intimate substance' and is therefore discouraged (ibid.). In her more recent work on blood in clinical labs in Malaysia, Carsten (2019b) suggests how the way food is consumed together by lab technicians during their lunch breaks often works to initiate friendships between colleagues, to signal the thickening and thinning of relations, and, over time, even to generate kinship relations (Carsten 2019b: 175). She argues that food acts as a 'barometer of the warmth and strength of connections', and therefore as a 'kind of moral barometer of social relations' (ibid.: 171). This work parallels her recent call for focusing on what kinship *does*, rather than on what kinship is (Carsten 2019a: 133) – which means also focusing on the *effects* of kinship, especially on the effects of kinship through time. Answering Carsten's call in a way that contributes to examining the implications of 'feeding' for theories of relationship formation, the ethnographic material in this book will offer an example of a world in which feeding is indeed deemed to be not only crucial to the development of 'healthy bonding' and 'healthy development', but also to be something that *stands for* this healthiness: irregularities in feeding, we will see, are here conceived as symptoms, and symbols, of something gone awry in the bonding process, with certain parenting practices being considered detrimental to the creation of 'healthy affective bonds' and therefore of 'healthy eating'.

The few anthropologists who have been exploring how parental feeding practices intersect with local ideas of development and good parenting tend to frame caring through food as a hitherto neglected *alternative* to 'psychological' warmth and 'attention to emotions'.[20] Francesca Mezzenzana (2020, 2021), for example, shows how the Runa of the Ecuadorian Amazon do not tend to verbally speculate about others' 'inner feelings' or 'thoughts', nor to talk about 'emotions' with their children. She argues that care and love are, instead, entirely conceived as being manifested through feeding. She offers her case as an example that contrasts with normative European and North American practices of fostering emotional attachment, which focus on imagination and emotion talk. In my context, on the contrary, we will see that the two domains of 'feeding' and 'psychological warmth' are intimately linked.

At the same time, however, my research contributes to that strand of anthropological literature which, in the face of the current conceptual priority given to 'relationality', reconsiders the potential of 'detachment' and its value in specific settings, recognising that 'engagement' and 'detachment' are interwoven in complex ways (Candea et al. 2015: 1–14).[21] In arguing that treatment practices for eating disorders in my field site turn kinship care into a therapeutic tool for the professionals, the book will draw on and go beyond works that, by looking at kinship in practice, have usefully explored the ambivalent and potentially harmful side of kinship (e.g., Carsten 2019a; Das 1995; Lambek 2011; Pinto 2014), and have highlighted how kinship can be framed as a source of mental distress and at the same time as a resource for remedy (Bradely and Ecks 2018; Buchbinder 2015; Chua 2011). These have variously shown the intricacies between mental health and kinship, and how medical practice engages in kin work by seeking to define the appropriate mechanics of kin care. They have also contributed to challenging the supposed boundaries between a 'domestic' sphere of kinship and a 'public' sphere of work (see McKinnon and Cannell 2013). This book will show how healthcare professionals struggle to build and maintain those boundaries precisely because they need to constantly traverse them in their everyday work.

Outline of Chapters

In Chapter 1, I first situate my field site by tracing a brief history of how 'eating disorders' emerged in medicine and gradually in psychiatry in Italy, and of how their treatment developed accordingly. Second, I zoom in on the treatment centre where I conducted fieldwork, locating its approach within this history and introducing its inhabitants. I then discuss my research methods, my positionality in the field as researcher and volunteer, the implications of this double role and the way I dealt with the ethical issues I encountered.

Chapter 2 introduces the key tensions of the book, by asking: what are 'eating disorders' about? Here I examine the different ways in which patients and professionals construct the causes, manifestations and effects of the eating disorder. Drawing on both previous ethnographic literature on patients' experiences and on my own fieldwork, I suggest that patients frame their eating disorder as a self-care project, but that their self-shaping practices point strongly to relational aspects – i.e., to how these people's self-projects are about selves in relationships. I then examine how, through the patient's assessment preceding admission, what might be experienced by patients as a self-care practice is framed by professionals as pathology, diagnosed and then treated through a careful tracking of the patient's body and mind performed by biomedicine and the psychological sciences. I show that patients' and professionals' diverging constructions, however, have something in common: eating disorders, both parties seem to be saying, *appear* to be about food but are not 'really' about food. Instead, they frame food, the body and weight as the vehicles of a distress that has something to do with relatedness. I also show that in this context of care symptoms are ascribed to an entity that is at the same time external to and within the patient; in this way, professionals construct a partible 'eating disordered self' that helps them make sense not only of the failures of treatment (as in Lester 2007, 2019), but also of the everyday care practices that are seemingly necessary for treatment 'to work'. By framing their somewhat coercive measures as directed 'to the eating disorder, not to the person', professionals try to resolve the tension between care and coercion.

Chapter 3 then traces how patients who are mostly brought to treatment by their family members, and who are seen to be in need of constant surveillance, get to the point of assuming responsibility for doing and avoiding the very things that professionals have forced them to do and avoid at the beginning of treatment. I show how treatment, in its ordering of time, space and therapeutic activities, induces patients to gradually deal with that responsibility by cultivating their 'awareness' – that is, a shift from seeing their condition as a self-care project to seeing it as a form of enslavement to an external force that 'took over their minds' and literally 'blurred their vision', neurologically 'distorting' the way they see their own bodies. I also show that what is conceived as the nutritional aspect of food needs to be momentarily separated from its kinship-making aspect, because problems in the latter are seen to be impeding the former. Treatment, in other words, here means gradually substituting patients' ways of being well with a definition of health that is jointly constituted by the professionals through the use of scientific knowledge and its apparently impartial numbers. Once this shift has occurred, we will see, patients are deemed capable of being responsible for a self-transformation that will enhance their health.

Since eating disorders are seen by professionals as markers of 'things gone awry in family relations', Chapters 4 and 5 show that this work of transformation is felt to succeed only if the patient's family is transformed too. Here, the sociality of patients' bodies is seen to be as important as their physiology. Chapter 4 argues that the treatment team tinkers with kinship care by purposefully functioning as a 'relational laboratory', as the professionals channel what they see as the dangerous aspects of kinship into therapeutic tools. They do so by 'borrowing' from kinship care in their therapeutic work whilst tinkering with its constitutive practices, cleaning it of its perceived dysfunctionality. I thus show how kinship here not only has an ambivalent and potentially harmful side – whereby the patient's family can be framed as a source of distress; kinship can also become a therapeutic tool, in the double sense that i) professionals work to reshape kinship care in patients' families by turning them into resources for recovery, and ii) that professionals simultaneously borrow from kinship practices in their own therapeutic work of 'reparenting' patients. Kinship is thus operationalised into a therapeutic tool, although a risky one to use.

Chapter 5 explores one of the instances in which the transformation sought in patients and their families does not seem to happen. It suggests that treating 'preadolescents' with eating disorders – a recent and increasingly prevalent phenomenon in Italy and elsewhere – puts into question the very paradigm of treatment, because children fail to undergo the desired steps deemed essential for therapeutic transformation. In this chapter I show how children do not become 'aware' of being in need of help and do not reach the point when they want to abandon the eating disorder, failing to assume responsibility for their own treatment. The reasons for this failure are located by the treatment team in patients' 'dysfunctional families' – in their failure to care for their children in a way that provides them with 'boundaries'. These families seem to be so dysfunctional that they cannot even be tinkered with. This makes it more difficult for the professionals to stay clinically detached, because what should be a temporary reparenting role then lacks a foreseeable end. Such an impasse forces professionals (and anthropologists) to rethink treatment and to experiment with other ways of treating children.

Chapter 6 covers another category of cases in which the transformation sought in patients and their families does not happen in the way professionals would expect, as the patients' and the professionals' diverging constructions of the eating disorder keep clashing, generating what the treatment team experiences as 'failure': 'chronic' patients show that the time of treatment and the time of illness intersect in important ways with the kind of care that is seen as key to patients' recovery. The chapter looks at how professional and family carers experience and deal with the limits of their own care, and shows that 'chronicity' and 'comorbidity' put into question two of the pillars that constitute the logic of the treatment model: i) family-based care and ii) framing the eating disorder as a part of the patient's self that can be dispensed with. I suggest that although failure materialises in patients' bodies – which 'fail' to gain weight or to maintain what is seen as a healthy weight gain – it is mostly relationships of kinship care that are seen to be failing, further showing how tinkering with family is difficult work. These cases suggest, however, that even when treatment 'doesn't work' what is perceived as 'failure' becomes productive, because it motivates professionals to try and improve the patient's condition in a different way, generating more attuned attempts of care – which at times seem to work and at others seem to fail too.

The conclusion, finally, brings the chapters together by illustrating how they enable us to think more about the complexity of bodies and diseases and of food and kinship. Here I highlight how, in this treatment centre, patients' bodies are transformed through transforming the relations that constitute them. In doing so, I also look at what happens to patients after discharge from Il Giardino, focusing on whether the family work that is done during residential treatment and that is considered crucial for long-lasting recovery 'travels back' to patients' homes once they are discharged from the facility, and with what kind of short- and long-term effects. Finally, I ask whether 'work with the family' is enough, how it can be improved, and whether perhaps we also need more work with, and more care from, a wider 'social' that keeps harming patients outside the protected environment of treatment facilities.

Notes

1. The name of the treatment centre has been invented by the author, and some of its identifying features omitted, to maintain the anonymity of its inhabitants.

2. The Italian National Health Service (*Servizio Sanitario Nazionale*) was set up in 1978. The central government controls the distribution of tax revenue for publicly financed healthcare and defines the 'essential levels of care' (*livelli essenziali di assistenza*) to be offered to all residents in every Italian *regione* (region). The *regioni* – the first-level administrative divisions of the Italian Republic – are responsible for organising health services through local health units, which deliver primary care, hospital care, outpatient specialist care, public healthcare and healthcare related to social care.
3. The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) is presented by the American Psychiatric Association as the product of years 'of effort by hundreds of international experts in all aspects of mental health' resulting in 'an authoritative volume that defines and classifies mental disorders in order to improve diagnoses, treatment, and research' (see https://www.psychiatry.org/psychiatrists/practice/dsm).
4. E.g., Green 2013; Hendricks 2003; Hornbacher 1998; Marzano 2011.
5. E.g., for Italy, see Bozzola 2024; Corica 2022; De Bac 2024; for the UK, see Addley 2023; Harris 2024.
6. E.g., the American Netflix movie *To the Bone* (Noxon 2017), in which we also have glimpses of the functioning of a residential clinic in the United States, and, even earlier, the Italian movie *Maledimiele* (Pozzi 2010) and the Rai Fiction movie *Briciole* (Cirino 2005).
7. E.g., the British series *Everything Now* (Parker 2023), the Italian series *SKAM Italia* (season 6, 2024) and the Spanish series *Madres* (Barbero and Gabilondo 2020–22).
8. E.g., in the UK the BBC documentary *I Am a Child Anorexic* (BBC 2006); in Italy the Rai 3 documentary *Fame d'amore* (Casadio 2020–25).
9. The 'calorie' was first defined in 1824 by the French physicist and chemist Nicolas Clément as a unit of heat energy in studies of fuel efficiency for the steam engine. The American chemist Wilbur Atwater introduced the 'kilocalorie' in 1887, to measure the potential energy from food to support human labour (Hargrove 2007). As we will see, in the world of eating disorders food becomes 'calories' and persons become the morally charged numbers of their 'weight': the lower the numbers, the more praised the food/person is.
10. See, for instance, Addley 2023 in the UK; Bozzola 2024 in Italy.
11. In the publications of the *DSM-IV* (American Psychiatric Association 1994) and *DSM-IV-TR* text revision (ibid.: 2000), respectively, diagnostic categories were refined: anorexia nervosa can now be of 'restricting type' OR 'binge-purging type'; and bulimia nervosa is categorised as 'purging type' OR 'non-purging type' (bingeing followed by compensatory exercise or restrictive eating).
12. For more on this historical account, see Pearce 2004.
13. For more on how 'anorexia' was associated with 'hysteria', see Charcot 1889; Freud and Breuer 2004 [1895]; Janet 1907.
14. Before then, the 1952 *DSM-I* had listed anorexia nervosa as a 'psycho-physiologic reaction', and the 1968 *DSM-II* as a 'feeding disturbance' (American Psychiatric Association 1952, 1968).
15. This might arguably be the case because families in the United States still tend to be excluded or sidelined in treatment, and because with patients over eighteen families are not involved in order to protect the ill family member's 'privacy'. Furthermore, as Lester (2019: 44) discusses, standard family-based therapies tend to be based on the idea of the stereotypical adolescent patient with two parents and the luxury of having at least one of them at home to supervise all meals, but this is hardly possible

in single-parent households or in families with trauma, substance abuse, or other mental health issues.

16. This military metaphor in medicine dates to the nineteenth century. It came into wide use in the 1880s when bacteria were identified as the agents of disease (Sontag 1978: 66).
17. See also Kleinman 2010: 23–24.
18. On these matters, see Brodwin 2011, 2013; Davis 2012; Myers 2015.
19. For a helpful tracing of the history of anthropology on Italian kinship, see Bonaccorso 2009: 7–10; Grilli 2019 offers a good mapping of more contemporary literature.
20. See Mezzenzana 2021 and Funk 2021.
21. See also Anderson 2001.